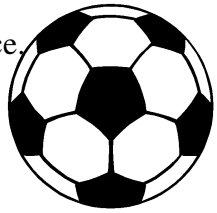
YOU MAY WRITE ONE CHECK PER FAMILY – PAYABLE TO MIDDLESEX REC. DEPT.
FILL OUT ONE FORM PER CHILD

You can mail to 1200 Mountain Ave., Middlesex, NJ 08846 or drop off at the office.
For questions or to volunteer please call (732) 356-7400 X7
*** PROGRAM IS OPEN TO MIDDLESEX BOROUGH RESIDENTS ONLY ***



2016 RECREATION SOCCER

$50.00 Registration Fee

Children entering grades K through 8 in September of 2016 are eligible to participate. All *games* will be played on Saturday's, September through November. Practice is typically once a week and at the complete discretion of the volunteer coach. We cannot guarantee or promise a set day and/or time for practices. No late registrations will be accepted. A waitlist will be started after the deadline. If we can accommodate children from the waitlist, a $10 late fee will be collected for ALL late registrations. No refunds will be given after 8/19/16. Refunds prior to 8/19/16 are subject to a 10% administrative withdrawal fee. **WE NEED VOLUNTEER COACHES – MINIMUM of TWO ADULTS** per team. Games/practices will not begin unless we meet the minimum for volunteers. If you would like information about the responsibilities of a volunteer coach please call the office.

DEADLINE TO REGISTER IS MONDAY, AUGUST 1, 2016

NAME (*print CLEARLY*)_____ DOB _____/_____/_____ BOY / GIRL
CIRCLE ONE

ADDRESS_____ CONTACT PHONE #( ) _____-_____

GRADE ENTERING IN **SEPT**._____ SCHOOL (entering in Sept.) _____

____I WOULD LIKE TO VOLUNTEER TO COACH SOCCER THIS YEAR. Name:_____

Coach Shirt Size: _____

Address IF DIFFERENT than above:_____ # to be reached at:_____

EMERGENCY TREATMENT RELEASE

Dates during which release is granted **– FROM: September 1, 2016 TO: November 30, 2016**

TO WHOM IT MAY CONCERN: As a parent and/or guardian of the minor named above, I herewith authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent(s)/Guardian Info:

_____ _____Ph # _____ Cell #_____
Parent Name address (if different than above)

_____ _____Ph # _____Cell #_____
Parent Name address (if different than above)

Contact Email _____ Hospital Preference_____

Other contact in case of emergency (required):

Name _____Phone_____ H / W / C Relationship to child_____

Specific medical allergies, chronic illness or other medical conditions the staff should be aware of:_____

_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. I confirm that my child is up to date on all immunizations as required by the NJ Dept. of Health and Senior Services Annual Immunizations Report. I also agree that all the information provided is correct and factual. If information is found to be false, I understand that my child will be expelled from program without reimbursement of fees paid.

Parent Signature_____ Date: _____/_____/_____

RCVD RCPT